Due to changes in Federal Regulations (Date January 25, 1999; Volume 64, Number 15, Pages 3637-3650) the following information is necessary for non-emergency transportation.

CERTIFICATE OF MEDICAL NECESSITY FOR AMBULANCE TRANSPORTATION

Patient Name: _____HIC#_____

Date of Transport: _____

I certify that the above patient requires a stretcher transport in an ambulance and that transport by any other means is contraindicated for the following reason(s):

_____

_____

_____

_____

_____

If this is a transport to another hospital, I certify that the patient must be transferred for the following tests or procedures that are not available at this facility:

_____

_____

_____

_____

_____

Physician Signature_____Date_____

UPIN#_____